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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JUDY KAYE LEWIS, a.k.a. JUDY GOFORTH, a.k.a. JUDY LEWIS-GOFORTH** 9549 Orion Drive Windsor, California 95492 Registered Nurse License No. 530127 Respondent.	Case No. 2008-367 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 26, 1997, the Board of Registered Nursing issued Registered Nurse License Number 530127 to Judy Kaye Lewis, also known as Judy Goforth, also known as Judy Lewis-Goforth (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2009, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the lapsing or voluntary surrender of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . .
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> (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . .

8. Section 2762 of the Code states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

9. Code section 4022 provides:

> "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
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> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

10. Section 4059, subdivision (a), of the Code provides, in pertinent part, that "[n]o person shall furnish any dangerous drug, except upon the prescription of a physician . . ."

11. Section 4060 of the Code provides, in pertinent part that "[n]o person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician . . ."

12. Section 11173, subdivision (a), of the Health and Safety Code provides:

> No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact.

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REGULATORY PROVISIONS

13. California Code of Regulations, title 16, section 1442, states: As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

14. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

15. **"Demerol"** is a brand name for Meperidine Hydrochloride, a derivative of Pethidine. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17) and a dangerous drug within the meaning of Code section 4022.

16. **"Dilaudid"** is a brand of Hydromorphone Hydrochloride, a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(K) and a dangerous drug as defined by Code section 4022. It is a narcotic analgesic.

17. **"Fentanyl"** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the meaning of Code section 4022.

18. **"Norco"** and "Vicodin" are the brand names for Hydrocodone Bitartrate (a semisynthetic narcotic analgesic and antitussive with multiple actions qualitatively similar to those of codeine) & Acetaminophen. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(3) and a dangerous drug pursuant to Business and Professions Code section 4022.

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19. **"Lorazepam,"**also known as the brand name Ativan, is a benzodiazepine, used for the management of anxiety disorders and for purposes of preoperative sedation and anxiety relief. Lorazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(13), and a dangerous drug within the meaning of Code section 4022.

20. **"Methadone"** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(14) and a dangerous drug as designated by Business and Professions Code section 4022. It is a narcotic drug and a synthetic opioid.

21. **"Oxycodone"** is the generic name for Percocet. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(N) and a dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone is an opioid agonist used as analgesia.

FACTUAL SUMMARY

Santa Rosa Memorial Hospital

22. From March 19, 2001 to May 24, 2005, Respondent worked as a registered nurse at Santa Rosa Memorial Hospital located in Santa Rosa, California.

23. On May 18, 2005, Respondent was observed to have slurred speech, dilated pupils, dry cotton mouth, and to be sweating and complaining of nausea and dizziness while on duty at Santa Rosa Memorial Hospital.

24. On or about May 24, 2005, Respondent was placed on administrative leave.

25. From on or about April 1, 2005 to May 18, 2005, during the course of her employment at Santa Rosa Memorial Hospital, Respondent committed the following acts:

A. **Patient 1**[1]: Patient 1's physician ordered Demerol 75 mg to be administered every 3 hours, as needed for severe pain. On or about April 1, 2005, at

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1. All patients are identified by numbers in order to preserve patient confidentiality. The medical record numbers of these patients will be disclosed pursuant to a request for discovery.

approximately 1538 hours, Respondent obtained a 100 mg dose of Demerol from the PYXIS[2] system for administration to Patient 1. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 4, 2005 at approximately 1828 hours, Respondent obtained a 100 mg dose of Demerol from the PYXIS system for administration to Patient 1. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 4, 2005 at approximately 2154 hours, Respondent obtained a 100 mg dose of Demerol from the PYXIS system for administration to Patient 1. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. At approximately 1530 hours, the nursing notes, written by another nurse, stated that Patient 1 had been administered Demerol and that he "feels much better."

On or about April 5, 2005 at approximately 2014 hours, Respondent obtained a 100 mg dose of Demerol from the PYXIS system for administration to Patient 1. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 6, 2005 at approximately 1800 hours, Respondent obtained a 100 mg dose of Demerol from the PYXIS system for administration to Patient 1. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

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2. PYXIS is a system for the automated dispensing and management of medications at the point of use in hospital settings.

B. **Patient 2**: Patient 2's physician ordered ½ to 2 tablets of Norco 10 mg to be administered every 3 to 4 hours, as needed for pain. On or about April 8, 2005, at approximately 1739 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 2. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On the same date, at approximately 2015 hours and again at 2111 hours, Respondent obtained 1 tablet of Norco10 mg from the PYXIS system for administration to Patient 2. Respondent documented the administration of the medication on the patient's medication administration record, however, the amount of medication removed exceeded the amount indicated in the physician's orders.

On or about April 10, 2005, at approximately 1603 hours, Respondent obtained 1 tablet of Norco 10 mg from the PYXIS system for administration to Patient 2. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On the same date, at approximately 1826 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 2. Respondent documented the administration of the medication on the patient's medication administration record. Additionally, the total amount of medication removed from the PYXIS system 1603 hours and 1826 hours exceeded the amount indicated in the physician's orders.

On April 18, 2005, at approximately 2057 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 2. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

C. **Patient 3**: Patient 3's physician ordered ½ to 2 tablets of Norco 10 mg to be administered every 3 hours, as needed for pain. On or about April 18, 2005, at approximately 1603 hours, Respondent obtained 1 tablet of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent failed to document the administration of the medication

on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On the same date, at approximately 1604 hours, Respondent obtained 1 tablet of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On the same date, at approximately 1656 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent documented the administration of the medication on the patient's medication administration record, however, the amount of medication removed exceeded the amount indicated in the physician's orders.

On or about April 19, 2005, at approximately 2051 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 20, 2005, at approximately 2313 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 26, 2005, at approximately 1437 hours, Respondent obtained 2 tablets of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

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On or about April 28, 2005, at approximately 1903 hours, Respondent obtained 1 tablet of Norco 10 mg from the PYXIS system for administration to Patient 3. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

D. **Patient 4**: Patient 4's physician ordered 2 tablets of Oxycodone IR 5 mg to be administered every 4 hours, as needed for pain. On or about April 20, 2005, at approximately 2314 hours, Respondent obtained 2 tablets of Oxycodone IR 5 mg from the PYXIS system for administration to Patient 4. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 24, 2005, at approximately 1709 hours, Respondent obtained 2 tablets of Oxycodone IR 5 mg from the PYXIS system for administration to Patient 4. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

On or about April 28, 2005, at approximately 1906 hours, Respondent obtained 2 tablets of Oxycodone IR 5 mg from the PYXIS system for administration to Patient 4. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

E. **Patient 5**: Patient 5's physician ordered Dilaudid SQ 1 mg to be administered every 2 hours, as needed. On or about May 8, 2005, at approximately 1520 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

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On the same date, at approximately 1548 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent documented the administration of the medication on the patient's medication administration record, however, the amount of medication removed exceeded the amount indicated in the physician's orders. Additionally, the total amount removed at 1520 hours and 1548 hours exceeded the amount indicated in the physician's orders.

On the same date, at approximately 1854 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent documented the administration of 1 mg of the medication on the patient's medication administration record but failed to chart the wastage of or otherwise account for the remaining medication.

On or about May 11, 2005, at approximately 1641 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

On the same date, at approximately 1706 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent documented the administration of 1 mg of the medication on the patient's medication administration record, however, the amount removed at 1641 hours and 1706 hours exceeded the amount indicated in the physician's orders.

On or about May 16, 2005, at approximately 1455 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent documented the administration of 1 mg of the medication on the patient's medication administration record but failed to chart the wastage of or otherwise account for the remaining medication. Patient 5's medical records indicate that all pain medications were to be held due to sedation and that no other nurse administered Dilaudid to Patient 5 that day.

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On the same date, at approximately 1803 hours, Respondent obtained 2 mg of Dilaudid SQ from the PYXIS system for administration to Patient 5. Respondent documented the administration of 1 mg of the medication on the patient's medication administration record but failed to chart the wastage of or otherwise account for the remaining medication.

Patient 5's physician ordered 3 tablets of Oxycodone IR 5 mg to be administered every 3 hours, as needed. On or about May 10, 2005, at approximately 1506 hours, Respondent obtained 3 tablets of Oxycodone IR 5 mg from the PYXIS system for administration to Patient 5. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. Additionally, another nurse documented the administration of 3 tablets of Oxycodone IR 5 mg to Patient 5 at 1700 hours.

On or about May 11, 2005, at approximately 2006 hours, Respondent obtained 2 tablets of Oxycodone 20 mg from the PYXIS system for administration to Patient 5. Respondent failed to documented the administration of the medication on the patient's medication administration record and failed to chart the wastage of or otherwise account for the remaining medication.

Patient 5's physician ordered 2 tablets of Methadone 10 mg to be administered three times a day. On or about May 11, 2005, at approximately 2006 hours, Respondent obtained 2 tablets of Methadone 20 mg from the PYXIS system for administration to Patient 5. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

Patient 5's physician ordered 1 tablet of Diazepam 5 mg to be administered three times a day. On or about May 16, 2005, at approximately 20038 hours, Respondent obtained 2 tablets of Diazepam 5 mg from the PYXIS system for administration to Patient 5. Respondent documented the administration of 1 tablet of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the remaining medication.

F. **Patient 6**: Patient 6's physician ordered ½ to 2 tablets of Norco 10 mg to be administered every 4 hours, as needed for pain. On or about May 10, 2005, at approximately 1504 hours, Respondent obtained 1 tablet of Norco 10 mg from the PYXIS system for administration to Patient 6. Respondent charted the word "error" on the patient's medication administration record but failed to chart the wastage of or otherwise account for the medication.

G. **Patient 7**: Patient 7's physician ordered .5 mg to 1 mg of Dilaudid to be administered every hour, as needed. On or about May 12, 2005, at approximately 1649 hours, Respondent obtained 2 mg of Dilaudid from the PYXIS system for administration to Patient 7. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders. Additionally, Patient 7's medication administration record states that at 1645 hours, Oxycodone IR 5 gm and Ativan 2 mg were administered, with reduced pain.

H. **Patient 8**: Patient 8's physician ordered 1 mg of Lorazepam to be administered every 4 hours, as needed. On or about May 16, 2005, at approximately 1738 hours, Respondent obtained 2 mg of Lorazepam from the PYXIS system for administration to Patient 8. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

I. **Patient 9**: Patient 9's physician ordered 1 tablet of Oxycodone IR 5 mg to be administered every 4 hours, as needed for pain. On or about May 18, 2005, at approximately 1611 hours, Respondent obtained 1 tablet of Oxycodone IR 5 mg from the PYXIS system for administration to Patient 9. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

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Sonoma Valley Hospital

26. In July 2007, Respondent worked as a registered nurse at Sonoma Valley Hospital located in Sonoma, California.

27. From on or about July 28, 2007 to July 31, 2007, during the course of her employment at Sonoma Valley Hospital, Respondent committed the following acts:

A. **Patient 10**: On or about July 28, 2007, at 0145 hours, Respondent obtained Fentanyl 100 mcg from the PYXIS system for administration to Patient 10. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. There was no physician order for Fentanyl 10 mcg to be administered to Patient 10.

B. **Patient 11**: Patient 11's physician ordered Dilaudid .5 mg to be administered every 15 minutes, as needed for pain. On or about July 31, 2007, at 1929 hours, Respondent obtained Dilaudid 1mg from the PYXIS system for administration to Patient 11. Respondent failed to document the administration of the medication on the patient's medication administration record. Additionally, Patient 11's nurses notes state that on or about July 31, 2007, at 2000 hours, Patient 11 had continued to refuse all pain medications. On or about August 1, 2007, at 0606 hours, Respondent asked another nurse to input her biometric scan to witness the wasting of the Dilaudid 1 mg, the nurse was then called to attend a patient's room and Respondent claimed that she wasted the Dilaudid 1mg without the other nurse being present.

On or about August 1, 2007, at 0558 hours, Respondent obtained Dilaudid 1mg from the PYXIS system for administration to Patient 11. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. Additionally, Patient 11's nurses notes state that at on this same date, at 0400 hours and 0800 hours, Patient 11 had continued to refuse all pain medications.

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FIRST CAUSE FOR DISCIPLINE

(UNPROFESSIONAL CONDUCT: GROSS NEGLIGENCE)

28. Complainant realleges the allegations set forth in Paragraphs 22 through 25 and their sub-parts, above, which are herein incorporated by reference as though fully set forth.

29. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), of the Code for unprofessional conduct, as defined by California Code of Regulations, title 16, section 1442, in that while employed as a registered nurse at Santa Rosa Memorial Hospital in Santa Rosa, California and at Sonoma Valley Hospital located in Sonoma, California, she committed acts of gross negligence in carrying out her usual certified or licensed nursing functions. Specifically, respondent was grossly negligent in that on the occasions more particularly set forth in Paragraphs 22 through 25 and their sub-parts, above, she committed the following acts:

a. Failed to account for controlled substances;

b. Failed to accurately document the care provided (the amount of narcotic medications that she purportedly administered);

c. Withheld care from a patient (in the form of pain relief);

d. Diverted narcotic medications from the PYXIS System; and

e. Falsified patient records upon which the patients are billed (fraud).

SECOND CAUSE FOR DISCIPLINE

(UNPROFESSIONAL CONDUCT: OBTAINING AND/OR POSSESSION OF A CONTROLLED SUBSTANCE AND/OR DANGEROUS DRUG)

30. Complainant realleges the allegations set forth in Paragraphs 22 through 27 and their sub-parts, above, which are herein incorporated by reference as though fully set forth.

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31. Respondent's registered nurse license is subject to discipline under section 2761(a) of the Code for unprofessional conduct, as defined by Code section 2762(a), in that while employed as a registered nurse at Santa Rosa Memorial Hospital in Santa Rosa, California and Sonoma Valley Hospital in Sonoma, California, she committed the following acts:

a. Respondent unlawfully obtained and possessed the following controlled substances in violation of Code section 4060: Demerol, Dilaudid, Fentanyl, Norco, Ativan, Methadone, and Oxycodone;

b. Respondent unlawfully obtained the following controlled substances by fraud, deceit, misrepresentation, subterfuge and/or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a): Demerol, Dilaudid, Fentanyl, Norco, Ativan, Methadone, and Oxycodone; and

c. Respondent unlawfully obtained and possessed the following dangerous drugs in violation of Code section 4059, subdivision (a): Demerol, Dilaudid, Fentanyl, Norco, Ativan, Methadone, and Oxycodone.

THIRD CAUSE FOR DISCIPLINE

(UNPROFESSIONAL CONDUCT: FALSIFYING OR MAKING INCORRECT OR INCONSISTENT ENTRIES IN RECORDS)

32. Complainant realleges the allegations set forth in Paragraphs 22 through 27 and their sub-parts, above, which are herein incorporated by reference as though fully set forth.

33. Respondent's registered nurse license is subject to discipline under section 2761, subdivision (a), of the Code for unprofessional conduct, as defined by Code section 2761, subdivision (e), in that while employed as a registered nurse at Santa Rosa Memorial Hospital in Santa Rosa, California and Sonoma Valley Hospital in Sonoma, California, she made false, grossly incorrect, and/or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and dangerous drugs as set forth in Paragraphs 22 through 27, above.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 530127, issued to Judy Kaye Lewis, a.k.a. Judy Goforth, a.k.a. Judy Lewis-Goforth.

2. Ordering Judy Kaye Lewis to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 6.26.08

for RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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